PLATINUM HEALTH

Private Bag X82081, Rustenburg, 0300 • Tel: 014 590 1700 • zzgengagementofficemembership@platinumhealth.co.za • www.platinumhealth.co.za

MEMBERSHIP APPLICATION FORM

1. Please complete the application form in PRINT with black ink and forward to Platinum Health as per email address above.
2. The applicant must please complete all sections and sign the application form.
3. Ensure that sections 4 to 9 (medical history) for each individual applying for membership is completed in full.
4. Existing Platinum Health membership number to be included:

(Please indicate with a "X" where applicable)

☐ New member ☐ Existing member

1 DETAILS OF APPLICANT (Please complete in full)

Title: Prof | Dr | Mr | Ms Initials: Surname:

Names in full (as per identity document):

Preferred name: Email:

Tel no (Home): Tel no (Work): Cell no:

Identity or passport number:

Tax reference number:

Country of issue: Date of birth: C C Y Y M M D D

Postal address:

Postal code:

Residential address:

Postal code:

Sex: Male | Female Marital status: Married | Single | Divorced | Widow/er Date of marriage: C C Y Y M M D D

Language preference: Afrikaans | English Race: African | Asian/Indian | White | Coloured (As per legislation)

Must be registered with effect from: C C Y Y M M D D

2 EMPLOYMENT DETAILS (Please complete in full)

Employee number:

Workplace: Pay Point:

Start date: C C Y Y M M D D Tel no (Work):

Employer site/Shaft name:

3 CHOICE OF OPTION AND BANKING DETAILS (Please complete in full)

3.1 CHOICE OF BENEFIT OPTION

Which Platinum Health benefit option do you wish to apply for? | PLATCAP | PLATFREEDOM | PLATCOMPREHENSIVE |

3.2 INCOME INFORMATION

Salary band:

Payroll/HR name:

Payroll/HR name:

Fixed Term Contractor that is permitted on the medical scheme | Yes | No | Period |

Permanent Employee | Yes | No | From which date | C | C | Y | Y | M | M | D | D |

Date:

Signature:

OFFICIAL BUSINESS
UNIT STAMP

3.3 BANK DETAILS

Name of bank:

Account type: | Savings | Cheque | Transmission |

Account number:

Name of branch:

Branch code of bank:

Initials and surname of account holder:

Signature of account holder:

ATTACH BANK CONFIRMATION LETTER OR BANK STATEMENT

3.4 CARD DELIVERY/LOCATION

Card to be delivered to: ☐ Employer Operation/Site:

Card to be delivered to: ☐ Client Liaison (175 Beyers Naude Avenue, Rustenburg)

DOCUMENTATION REQUIRED TO BE ATTACHED WHEN REGISTERING DEPENDANTS:

1. SPOUSE – COPY OF SPOUSE'S IDENTITY DOCUMENT AND MARRIAGE CERTIFICATE
2. CHILDREN / STEPCHILD – CERTIFICATE OF BIRTH / IDENTITY DOCUMENT
3. CHILDREN 21 YEARS OR OLDER – PROOF OF STUDY AND PROOF OF DEPENDANT CHILD'S INCOME
4. ADOPTED CHILDREN – COURT ORDER, IDENTITY DOCUMENT, BIRTH CERTIFICATE
5. FIANCÉE / COMMON-LAW PARTNER / LIFE PARTNER – AFFIDAVIT, IDENTITY DOCUMENT
6. PARENTS (NO IN-LAWS) – AFFIDAVIT, PROOF OF INCOME, IDENTITY DOCUMENT

4 MEDICAL HISTORY (Please complete in full)

The following questionnaire must be completed by all individuals who apply for membership. Platinum Health reserves the right to request a member to undergo a medical examination. Please answer all the questions.

4.1 MEDICAL HISTORY OF PRINCIPAL MEMBER

Name and surname:

Date of birth: C C Y Y M M D D

Identity or passport number:

HAVE YOU EVER SUFFERED FROM: (Mark with a "X")		
1. Any psychological or psychiatric illness or condition (eg. endogenous depression, depression, anxiety or stress)	Yes	No
2. Any neurological illness or condition (eg. epilepsy, fainting fits, paralysis, a stroke)	Yes	No
3. Any contagious disease (eg. HIV/Aids, tuberculosis, hepatitis B)	Yes	No
4. Any skin disease	Yes	No
5. Any affection of the skeleton and/or joints (eg. osteoporosis, rheumatism, gout, arthritis, back pain)	Yes	No
6. Any affection of the muscular system (eg. muscular dystrophy)	Yes	No
7. Any affection of the heart or circulatory system (eg. hypertension, coronary heart disease, chest pain or angina, irregular heart beat, rheumatic fever, vascular heart disease, valve lesions, heart murmurs, shortness of breath)	Yes	No
8. Any affection of the digestive system, liver or gall bladder (eg. stomach ulcers, hiatus hernia, indigestion, gall stones)	Yes	No
9. Any affection of the urinary system and/or genital organs (eg. bladder infection, pyelitis, renal calculus, prostatitis)	Yes	No
10. Any affection of the chest or respiratory system (eg. asthma, bronchitis, a chronic cough)	Yes	No
11. Any affection of the eyes, ears, nose or teeth	Yes	No
12. Any metabolic, congenital disorders (eg. diabetes, high cholesterol)	Yes	No
13. Any cancer or tumours (malignant or benign)	Yes	No
14. Any physical (including dental) illness or condition, or any deformity, drug or alcohol dependence problem or contagious condition, whether congenital or acquired	Yes	No
15. Any tropical disease (eg. malaria or bilharzia)	Yes	No
16. Any allergic conditions (eg. hay fever or sinusitis)	Yes	No
17. Any affection of the female organs (eg. uterus, ovaria, abnormal PAP smears, breasts, endometriosis, abnormal pregnancies, caesarean section)	Yes	No
18. Any illness or condition for which you or your dependants receive a gratuity, pension payment and/or guaranteed medical treatment from the Compensation Commissioner or War Pensions Department or Motor Vehicle Insurance Act	Yes	No
19. Is any female member/dependant currently pregnant?	Yes	No
20. Are you expecting surgery or planning hospitalisation or treatment in the next 12 months or have you been admitted to hospital in the past 12 months?	Yes	No
21. Do you have any symptoms not yet diagnosed by a medical professional or any condition which is not covered in above questionnaire?	Yes	No
22. Have you received medical advice or treatment from a medical professional in the 12 months before this application?	Yes	No

If the answer to any of the above is YES, please provide full details of the condition. Additional information may be attached. If the answer to any of the above is NO, it remains the responsibility of the Principal Member to prove that the medical condition was not due to a pre-existing condition.

Medical diagnosis:

Date of first diagnosis: C C Y Y M M D D

Currently on treatment for this condition: Yes No

Date of last symptoms, consultation or hospitalisation: C C Y Y M M D D

Medicine and dosage used for condition:

Date of medicine last taken: C C Y Y M M D D

IF YOU HAVE DECLARED CONDITIONS ABOVE YOU HAVE TO CONTACT CASE MANAGEMENT AT 014 590 1700 OR 080 000 6942 TO REGISTER ON A DISEASE MANAGEMENT PROGRAMME.

Principal Member Signature:

REGISTRATION OF SPOUSE OR LIFE PARTNER (Please complete in full)

Title: Initials: Surname:

Names in full (as per identity document):

Preferred name: Maiden name:

Cell: Sex: Male Female Date of birth: C C Y Y M M D D

Email:

Identity or passport number: Country of issue:

Residential address:

Postal code:

Was this dependent previously on Platinum Health? Yes No Previous member number

Spouse/partner must be registered with effect from: C C Y Y M M D D

(Attach copy of identity document and marriage certificate or affidavit for registration of a partner)

HAVE YOU EVER SUFFERED FROM: (Mark with a "X")		
1. Any psychological or psychiatric illness or condition (eg. endogenous depression, depression, anxiety or stress)	Yes	No
2. Any neurological illness or condition (eg. epilepsy, fainting fits, paralysis, a stroke)	Yes	No
3. Any contagious disease (eg. HIV/Aids, tuberculosis, hepatitis B)	Yes	No
4. Any skin disease	Yes	No
5. Any affection of the skeleton and/or joints (eg. osteoporosis, rheumatism, gout, arthritis, back pain)	Yes	No
6. Any affection of the muscular system (eg. muscular dystrophy)	Yes	No
7. Any affection of the heart or circulatory system (eg. hypertension, coronary heart disease, chest pain or angina, irregular heart beat, rheumatic fever, vascular heart disease, valve lesions, heart murmurs, shortness of breath)	Yes	No
8. Any affection of the digestive system, liver or gall bladder (eg. stomach ulcers, hiatus hernia, indigestion, gall stones)	Yes	No
9. Any affection of the urinary system and/or genital organs (eg. bladder infection, pyelitis, renal calculus, prostatitis)	Yes	No
10. Any affection of the chest or respiratory system (eg. asthma, bronchitis, a chronic cough)	Yes	No
11. Any affection of the eyes, ears, nose or teeth	Yes	No
12. Any metabolic, congenital disorders (eg. diabetes, high cholesterol)	Yes	No
13. Any cancer or tumours (malignant or benign)	Yes	No
14. Any physical (including dental) illness or condition, or any deformity, drug or alcohol dependence problem or contagious condition, whether congenital or acquired	Yes	No
15. Any tropical disease (eg. malaria or bilharzia)	Yes	No
16. Any allergic conditions (eg. hay fever or sinusitis)	Yes	No
17. Any affection of the female organs (eg. uterus, ovaria, abnormal PAP smears, breasts, endometriosis, abnormal pregnancies, caesarean section)	Yes	No
18. Any illness or condition for which you or your dependants receive a gratuity, pension payment and/or guaranteed medical treatment from the Compensation Commissioner or War Pensions Department or Motor Vehicle Insurance Act	Yes	No
19. Is any female member/dependant currently pregnant?	Yes	No
20. Are you expecting surgery or planning hospitalisation or treatment in the next 12 months or have you been admitted to hospital in the past 12 months?	Yes	No
21. Do you have any symptoms not yet diagnosed by a medical professional or any condition which is not covered in above questionnaire?	Yes	No
22. Have you received medical advice or treatment from a medical professional in the 12 months before this application?	Yes	No

If the answer to any of the above is YES, please provide full details of the condition. Additional information may be attached. If the answer to any of the above is NO, it remains the responsibility of the Principal Member to prove that the medical condition was not due to a pre-existing condition.

Medical diagnosis:

Date of first diagnosis: C C Y Y M M D D Currently on treatment for this condition: Yes No

Date of last symptoms, consultation or hospitalisation: C C Y Y M M D D

Medicine and dosage used for condition:

Date of medicine last taken: C C Y Y M M D D

IF YOU HAVE DECLARED CONDITIONS ABOVE YOU HAVE TO CONTACT CASE MANAGEMENT AT 014 590 1700 OR 080 000 6942 TO REGISTER ON A DISEASE MANAGEMENT PROGRAMME.

Principal Member Signature:

6 REGISTRATION OF DEPENDANT 1 (Please complete in full)

Title: Initials: Surname:

Names in full (as per identity document):

Preferred name: Sex: Male Female Date of birth: C C Y Y M M D D

Relationship to member: (For example, mother, child. If your child is not your biological child, please state the relationship i.e adopted child, foster child. Please provide legal proof.)

Identity or passport number: Country of issue:

Email:

Next of kin: Cell:

Residential address: Postal code:

Is your dependant: Married? Yes No Financially dependant on you? Yes No Disabled? Yes No A full-time student? Yes No

Does your dependant earn an income? Yes No If yes, how much does you dependant earn each month? R

Was this dependent previously on Platinum Health? Yes No Previous member number

This dependant must be registered with effect from: C C Y Y M M D D

HAVE YOU EVER SUFFERED FROM: (Mark with a "X")		
1. Any psychological or psychiatric illness or condition (eg. endogenous depression, depression, anxiety or stress)	Yes	No
2. Any neurological illness or condition (eg. epilepsy, fainting fits, paralysis, a stroke)	Yes	No
3. Any contagious disease (eg. HIV/Aids, tuberculosis, hepatitis B)	Yes	No
4. Any skin disease	Yes	No
5. Any affection of the skeleton and/or joints (eg. osteoporosis, rheumatism, gout, arthritis, back pain)	Yes	No
6. Any affection of the muscular system (eg. muscular dystrophy)	Yes	No
7. Any affection of the heart or circulatory system (eg. hypertension, coronary heart disease, chest pain or angina, irregular heart beat, rheumatic fever, vascular heart disease, valve lesions, heart murmurs, shortness of breath)	Yes	No
8. Any affection of the digestive system, liver or gall bladder (eg. stomach ulcers, hiatus hernia, indigestion, gall stones)	Yes	No
9. Any affection of the urinary system and/or genital organs (eg. bladder infection, pyelitis, renal calculus, prostatitis)	Yes	No
10. Any affection of the chest or respiratory system (eg. asthma, bronchitis, a chronic cough)	Yes	No
11. Any affection of the eyes, ears, nose or teeth	Yes	No
12. Any metabolic, congenital disorders (eg. diabetes, high cholesterol)	Yes	No
13. Any cancer or tumours (malignant or benign)	Yes	No
14. Any physical (including dental) illness or condition, or any deformity, drug or alcohol dependence problem or contagious condition, whether congenital or acquired	Yes	No
15. Any tropical disease (eg. malaria or bilharzia)	Yes	No
16. Any allergic conditions (eg. hay fever or sinusitis)	Yes	No
17. Any affection of the female organs (eg. uterus, ovaria, abnormal PAP smears, breasts, endometriosis, abnormal pregnancies, caesarean section)	Yes	No
18. Any illness or condition for which you or your dependants receive a gratuity, pension payment and/or guaranteed medical treatment from the Compensation Commissioner or War Pensions Department or Motor Vehicle Insurance Act	Yes	No
19. Is any female member/dependant currently pregnant?	Yes	No
20. Are you expecting surgery or planning hospitalisation or treatment in the next 12 months or have you been admitted to hospital in the past 12 months?	Yes	No
21. Do you have any symptoms not yet diagnosed by a medical professional or any condition which is not covered in above questionnaire?	Yes	No
22. Have you received medical advice or treatment from a medical professional in the 12 months before this application?	Yes	No

If the answer to any of the above is YES, please provide full details of the condition. Additional information may be attached. If the answer to any of the above is NO, it remains the responsibility of the Principal Member to prove that the medical condition was not due to a pre-existing condition.

Medical diagnosis:

Date of first diagnosis: C C Y Y M M D D Currently on treatment for this condition: Yes No

Date of last symptoms, consultation or hospitalisation: C C Y Y M M D D

Medicine and dosage used for condition:

Date of medicine last taken: C C Y Y M M D D

Principal Member Signature:

IF YOU HAVE DECLARED CONDITIONS ABOVE YOU HAVE TO CONTACT CASE MANAGEMENT AT 014 590 1700 OR 080 000 6942 TO REGISTER ON A DISEASE MANAGEMENT PROGRAMME.

7 REGISTRATION OF DEPENDANT 2 (Please complete in full)

Title: Initials: Surname:

Names in full (as per identity document):

Preferred name: Sex: Male Female Date of birth: C C Y Y M M D D

Relationship to member: (For example, mother, child. If your child is not your biological child, please state the relationship i.e adopted child, foster child. Please provide legal proof.)

Identity or passport number: Country of issue:

Email:

Next of kin: Cell:

Residential address: Postal code:

Is your dependant: Married? Yes No Financially dependant on you? Yes No Disabled? Yes No A full-time student? Yes No

Does your dependant earn an income? Yes No If yes, how much does you dependant earn each month? R

Was this dependent previously on Platinum Health? Yes No Previous member number

This dependant must be registered with effect from: C C Y Y M M D D

HAVE YOU EVER SUFFERED FROM: (Mark with a "X")		
1. Any psychological or psychiatric illness or condition (eg. endogenous depression, depression, anxiety or stress)	Yes	No
2. Any neurological illness or condition (eg. epilepsy, fainting fits, paralysis, a stroke)	Yes	No
3. Any contagious disease (eg. HIV/Aids, tuberculosis, hepatitis B)	Yes	No
4. Any skin disease	Yes	No
5. Any affection of the skeleton and/or joints (eg. osteoporosis, rheumatism, gout, arthritis, back pain)	Yes	No
6. Any affection of the muscular system (eg. muscular dystrophy)	Yes	No
7. Any affection of the heart or circulatory system (eg. hypertension, coronary heart disease, chest pain or angina, irregular heart beat, rheumatic fever, vascular heart disease, valve lesions, heart murmurs, shortness of breath)	Yes	No
8. Any affection of the digestive system, liver or gall bladder (eg. stomach ulcers, hiatus hernia, indigestion, gall stones)	Yes	No
9. Any affection of the urinary system and/or genital organs (eg. bladder infection, pyelitis, renal calculus, prostatitis)	Yes	No
10. Any affection of the chest or respiratory system (eg. asthma, bronchitis, a chronic cough)	Yes	No
11. Any affection of the eyes, ears, nose or teeth	Yes	No
12. Any metabolic, congenital disorders (eg. diabetes, high cholesterol)	Yes	No
13. Any cancer or tumours (malignant or benign)	Yes	No
14. Any physical (including dental) illness or condition, or any deformity, drug or alcohol dependence problem or contagious condition, whether congenital or acquired	Yes	No
15. Any tropical disease (eg. malaria or bilharzia)	Yes	No
16. Any allergic conditions (eg. hay fever or sinusitis)	Yes	No
17. Any affection of the female organs (eg. uterus, ovaria, abnormal PAP smears, breasts, endometriosis, abnormal pregnancies, caesarean section)	Yes	No
18. Any illness or condition for which you or your dependants receive a gratuity, pension payment and/or guaranteed medical treatment from the Compensation Commissioner or War Pensions Department or Motor Vehicle Insurance Act	Yes	No
19. Is any female member/dependant currently pregnant?	Yes	No
20. Are you expecting surgery or planning hospitalisation or treatment in the next 12 months or have you been admitted to hospital in the past 12 months?	Yes	No
21. Do you have any symptoms not yet diagnosed by a medical professional or any condition which is not covered in above questionnaire?	Yes	No
22. Have you received medical advice or treatment from a medical professional in the 12 months before this application?	Yes	No

If the answer to any of the above is YES, please provide full details of the condition. Additional information may be attached. If the answer to any of the above is NO, it remains the responsibility of the Principal Member to prove that the medical condition was not due to a pre-existing condition.

Medical diagnosis:

Date of first diagnosis: C C Y Y M M D D Currently on treatment for this condition: Yes No

Date of last symptoms, consultation or hospitalisation: C C Y Y M M D D

Medicine and dosage used for condition:

Date of medicine last taken: C C Y Y M M D D

Principal Member Signature:

IF YOU HAVE DECLARED CONDITIONS ABOVE YOU HAVE TO CONTACT CASE MANAGEMENT AT 014 590 1700 OR 080 000 6942 TO REGISTER ON A DISEASE MANAGEMENT PROGRAMME.

8 REGISTRATION OF DEPENDANT 3 (Please complete in full)

Title: Initials: Surname:

Names in full (as per identity document):

Preferred name: Sex: Male Female Date of birth: C C Y Y M M D D

Relationship to member: (For example, mother, child. If your child is not your biological child, please state the relationship i.e adopted child, foster child. Please provide legal proof.)

Identity or passport number: Country of issue:

Email:

Next of kin: Cell:

Residential address: Postal code:

Is your dependant: Married? Yes No Financially dependant on you? Yes No Disabled? Yes No A full-time student? Yes No

Does your dependant earn an income? Yes No If yes, how much does you dependant earn each month? R

Was this dependent previously on Platinum Health? Yes No Previous member number

This dependant must be registered with effect from: C C Y Y M M D D

HAVE YOU EVER SUFFERED FROM: (Mark with a "X")		
1. Any psychological or psychiatric illness or condition (eg. endogenous depression, depression, anxiety or stress)	Yes	No
2. Any neurological illness or condition (eg. epilepsy, fainting fits, paralysis, a stroke)	Yes	No
3. Any contagious disease (eg. HIV/Aids, tuberculosis, hepatitis B)	Yes	No
4. Any skin disease	Yes	No
5. Any affection of the skeleton and/or joints (eg. osteoporosis, rheumatism, gout, arthritis, back pain)	Yes	No
6. Any affection of the muscular system (eg. muscular dystrophy)	Yes	No
7. Any affection of the heart or circulatory system (eg. hypertension, coronary heart disease, chest pain or angina, irregular heart beat, rheumatic fever, vascular heart disease, valve lesions, heart murmurs, shortness of breath)	Yes	No
8. Any affection of the digestive system, liver or gall bladder (eg. stomach ulcers, hiatus hernia, indigestion, gall stones)	Yes	No
9. Any affection of the urinary system and/or genital organs (eg. bladder infection, pyelitis, renal calculus, prostatitis)	Yes	No
10. Any affection of the chest or respiratory system (eg. asthma, bronchitis, a chronic cough)	Yes	No
11. Any affection of the eyes, ears, nose or teeth	Yes	No
12. Any metabolic, congenital disorders (eg. diabetes, high cholesterol)	Yes	No
13. Any cancer or tumours (malignant or benign)	Yes	No
14. Any physical (including dental) illness or condition, or any deformity, drug or alcohol dependence problem or contagious condition, whether congenital or acquired	Yes	No
15. Any tropical disease (eg. malaria or bilharzia)	Yes	No
16. Any allergic conditions (eg. hay fever or sinusitis)	Yes	No
17. Any affection of the female organs (eg. uterus, ovaria, abnormal PAP smears, breasts, endometriosis, abnormal pregnancies, caesarean section)	Yes	No
18. Any illness or condition for which you or your dependants receive a gratuity, pension payment and/or guaranteed medical treatment from the Compensation Commissioner or War Pensions Department or Motor Vehicle Insurance Act	Yes	No
19. Is any female member/dependant currently pregnant?	Yes	No
20. Are you expecting surgery or planning hospitalisation or treatment in the next 12 months or have you been admitted to hospital in the past 12 months?	Yes	No
21. Do you have any symptoms not yet diagnosed by a medical professional or any condition which is not covered in above questionnaire?	Yes	No
22. Have you received medical advice or treatment from a medical professional in the 12 months before this application?	Yes	No

If the answer to any of the above is YES, please provide full details of the condition. Additional information may be attached. If the answer to any of the above is NO, it remains the responsibility of the Principal Member to prove that the medical condition was not due to a pre-existing condition.

Medical diagnosis:

Date of first diagnosis: C C Y Y M M D D Currently on treatment for this condition: Yes No

Date of last symptoms, consultation or hospitalisation: C C Y Y M M D D

Medicine and dosage used for condition:

Date of medicine last taken: C C Y Y M M D D

Principal Member Signature:

IF YOU HAVE DECLARED CONDITIONS ABOVE YOU HAVE TO CONTACT CASE MANAGEMENT AT 014 590 1700 OR 080 000 6942 TO REGISTER ON A DISEASE MANAGEMENT PROGRAMME.

9 REGISTRATION OF DEPENDANT 4 (Please complete in full)

Title: Initials: Surname:

Names in full (as per identity document):

Preferred name: Sex: Male Female Date of birth: C C Y Y M M D D

Relationship to member: (For example, mother, child. If your child is not your biological child, please state the relationship i.e adopted child, foster child. Please provide legal proof.)

Identity or passport number: Country of issue:

Email:

Next of kin: Cell:

Residential address: Postal code:

Is your dependant: Married? Yes No Financially dependant on you? Yes No Disabled? Yes No A full-time student? Yes No

Does your dependant earn an income? Yes No If yes, how much does you dependant earn each month? R

Was this dependent previously on Platinum Health? Yes No Previous member number

This dependant must be registered with effect from: C C Y Y M M D D

HAVE YOU EVER SUFFERED FROM: (Mark with a "X")		
1. Any psychological or psychiatric illness or condition (eg. endogenous depression, depression, anxiety or stress)	Yes	No
2. Any neurological illness or condition (eg. epilepsy, fainting fits, paralysis, a stroke)	Yes	No
3. Any contagious disease (eg. HIV/Aids, tuberculosis, hepatitis B)	Yes	No
4. Any skin disease	Yes	No
5. Any affection of the skeleton and/or joints (eg. osteoporosis, rheumatism, gout, arthritis, back pain)	Yes	No
6. Any affection of the muscular system (eg. muscular dystrophy)	Yes	No
7. Any affection of the heart or circulatory system (eg. hypertension, coronary heart disease, chest pain or angina, irregular heart beat, rheumatic fever, vascular heart disease, valve lesions, heart murmurs, shortness of breath)	Yes	No
8. Any affection of the digestive system, liver or gall bladder (eg. stomach ulcers, hiatus hernia, indigestion, gall stones)	Yes	No
9. Any affection of the urinary system and/or genital organs (eg. bladder infection, pyelitis, renal calculus, prostatitis)	Yes	No
10. Any affection of the chest or respiratory system (eg. asthma, bronchitis, a chronic cough)	Yes	No
11. Any affection of the eyes, ears, nose or teeth	Yes	No
12. Any metabolic, congenital disorders (eg. diabetes, high cholesterol)	Yes	No
13. Any cancer or tumours (malignant or benign)	Yes	No
14. Any physical (including dental) illness or condition, or any deformity, drug or alcohol dependence problem or contagious condition, whether congenital or acquired	Yes	No
15. Any tropical disease (eg. malaria or bilharzia)	Yes	No
16. Any allergic conditions (eg. hay fever or sinusitis)	Yes	No
17. Any affection of the female organs (eg. uterus, ovaria, abnormal PAP smears, breasts, endometriosis, abnormal pregnancies, caesarean section)	Yes	No
18. Any illness or condition for which you or your dependants receive a gratuity, pension payment and/or guaranteed medical treatment from the Compensation Commissioner or War Pensions Department or Motor Vehicle Insurance Act	Yes	No
19. Is any female member/dependant currently pregnant?	Yes	No
20. Are you expecting surgery or planning hospitalisation or treatment in the next 12 months or have you been admitted to hospital in the past 12 months?	Yes	No
21. Do you have any symptoms not yet diagnosed by a medical professional or any condition which is not covered in above questionnaire?	Yes	No
22. Have you received medical advice or treatment from a medical professional in the 12 months before this application?	Yes	No

If the answer to any of the above is YES, please provide full details of the condition. Additional information may be attached. If the answer to any of the above is NO, it remains the responsibility of the Principal Member to prove that the medical condition was not due to a pre-existing condition.

Medical diagnosis:

Date of first diagnosis: C C Y Y M M D D Currently on treatment for this condition: Yes No

Date of last symptoms, consultation or hospitalisation: C C Y Y M M D D

Medicine and dosage used for condition:

Date of medicine last taken: C C Y Y M M D D

Principal Member Signature:

IF YOU HAVE DECLARED CONDITIONS ABOVE YOU HAVE TO CONTACT CASE MANAGEMENT AT 014 590 1700 OR 080 000 6942 TO REGISTER ON A DISEASE MANAGEMENT PROGRAMME.

10 PREVIOUS MEMBERSHIP OF A MEDICAL SCHEME(S)

NB: If you (or your spouse/partner/any dependant) were a member/dependant of a medical scheme for the previous 24 months or longer, please attach certificates of membership (not membership cards) to this application form. The payment of benefits is usually subject to a waiting period of three months from the date of enrolment. Platinum Health may apply a waiting period of twelve months in respect of any pre-existing conditions that we may become aware of.

If a late penalty is applied as a result of the non-receipt of the above certificates, the necessary correction will come into effect on the first day of the month following the month in which the certificates were received.

Has this application been necessitated by a change in employment which resulted in the cancellation of your membership of the previous scheme? Yes | No

INCLUDE MEMBERSHIP CERTIFICATE OF PREVIOUS MEDICAL SCHEME TO AVOID INCORRECT APPLICATION WAITING PERIODS AND/OR LATE JOINER PENALTIES.

11 DECLARATION

11.1 PERMISSION TO PROCESS AND DISCLOSE INFORMATION AND TO COMMUNICATE WITH YOU

Platinum Health Medical Scheme may collect, collate, process and store your and all your dependants personal information, including health information, as provided in this application and any relevant information we get about you and your dependants:

- For providing any managed care services that you or any dependant on your health option may require;
- For providing relevant information to contracted third parties who require information to provide a healthcare service to you or any dependant on your health option; and
- To analyse and manage any risk to Platinum Health Medical Scheme.

The scheme will keep your and your dependants information confidential.

Platinum Health Medical Scheme may communicate with you about any changes in your health option, including any changes in your contributions or changes and enhancements to the benefits you are entitled to on the health option you hav e chosen.

Principal Member Signature:

11.2 GIVING INFORMATION

In order to consider your application for membership, Platinum Health Medical Scheme must learn more about you and your dependants, therefore it is important that you inform us about any medical condition, symptom or illness relating to you or your dependants, even if you do not consider it relevant to your application. We may ask any dependant older than 21 years for information and it will be treated as if we had asked you in your role as principal member.

Platinum Health Medical Scheme may at any time and on an ongoing basis, verify with the parties mentioned in this section that the information you provided on this application, and in respect of any matter pertaining to, or that arose during your membership of Platinum Health Medical Scheme, is true, correct and complete. You hereby give permission that Platinum Health Medical Scheme may request any information that is relevant to your application from your employer.

Principal Member Signature:

11.3 ROAD ACCIDENT FUND (RAF)

In the event of a motor vehicle accident involving a member and/or dependant within the borders of South Africa resulting in injuries and medical costs being paid by the Scheme, a member or dependant shall:

- be obliged to take all reasonable steps to recover the medical costs incurred by the Scheme from the Road Accident Fund;
- be obliged to take all reasonable steps to recover future and subsequent medical costs incurred after date of finalisation of the third party claim from the Road Accident Fund, in terms of an Undertaking issued by the RAF to a member or dependant relating to future medical costs;
- be obliged to provide the Scheme's attorneys with an Undertaking in terms whereof the member's attorney shall be obliged to make payment to the Scheme's attorneys of the medical expenses recovered from the Road Accident Fund, free of deduction of legal costs of the member's attorney, within 7 days upon receipt thereof irrespective whether payment is made by way of an interim payment or final payment; or
- be obliged to reimburse the Scheme the medical costs recovered from the Road Accident Fund, within 7 days upon receipt thereof irrespective whether payment is made by way of an interim payment or final payment.

The Scheme shall be entitled to terminate a member's membership or that of his/her dependants in the event that the provisions of these rules are breached.

"I hereby apply for membership of Platinum Health and agree that I will be bound by the rules of the Scheme as amended from time to time and undertake to familiarise myself with the rules of the Scheme and to obtain a copy thereof from Client Liaison or Membership, should I so wish. I hereby agree and consent to sign an Undertaking in favour of the Scheme, in the event that I or any of my dependants are involved in a motor vehicle accident resulting in the Scheme having to pay benefits in terms of the rules. I undertake to irrevocably instruct my attorney handling my third party claim against the Road Accident Fund, to counter sign the said Undertaking, to incorporate the hospital and medical expenses paid by the Scheme in the claim against the Road Accident Fund, to take all reasonable steps to recover the said amount from the Road Accident Fund and to pay the amount thus recovered, free of legal cost deduction to the Scheme's legal representatives. I hereby agree and consent that the Scheme may provide it's legal representatives with a copy of this form and also authorise the Scheme's legal representative to contact me in connection with the motor vehicle accident and to obtain a signed Undertaking in favour of the Scheme. I understand that if I do not have an attorney of my own choice to assist me with a third party claim against the Road Accident Fund, that the Scheme's legal representatives will assist me to lodge a claim with the Road Accident Fund, to ensure that the accident related hospital and medical expenses are recovered from the Road Accident Fund. I understand that should I not undertake to reimburse the Scheme or if I fail to honour my obligations in terms of the Scheme's rules and undertaking relating to past hospital and medical expenses paid on my behalf for injuries sustained by me or any of my dependants in the motor vehicle accident, any payments made by the Scheme will be reversed and will be for my own account. Furthermore, the Scheme will disvow liability of payment of any furter costs relating to the said vehicle accident."

Principal Member Signature: .....

11.4 INFORM US ABOUT CHANGES RIGHT AWAY

Should any information you supplied changes between the date you signed this application and the start date of your membership, you have to inform us by completing the "Request to change membership details, scheme option or card request" form and submit to Client Liaison. Members can obtain the form from Client Liaison at 014 590 1700 or PHMS website: www.platinumhealth.co.za.

11.5 NON-DISCLOSURE

The Scheme may exclude from benefits or terminate the membership of a member or dependant whom the Scheme finds guilty of abusing the benefits and privileges of the Scheme by presenting false claims or making a material misrepresentation or non-disclosure of factual information. In such event he may be required by the Scheme to refund to the Scheme any sum which, but for his abuse of the benefits or privileges of the Scheme, would not have been disbursed on his behalf.

11.6 ILLEGAL TO BE MEMBER OF TWO MEDICAL SCHEMES AT THE SAME TIME

It is illegal to be a member of more than one medical scheme at the same time. Proof of previous medical scheme membership is compulsory.

11.7 YOU MUST ENSURE CONTRIBUTIONS ARE PAID ON TIME

As the principal member of the scheme, you are responsible for ensuring that your contributions and the contributions of your dependants are paid on time every month.

You agree and accept responsibility for all unpaid contributions.

Principal Member Signature: .....

11.8 **MEMBERSHIP SUBJECT TO EMPLOYMENT**

Membership of Platinum Health Medical Scheme is subject to employment with your employer and will terminate on the same date as your employment with the exception of continuation members. Should claims be received by the medical scheme for treatment dates post your termination date, you as the main member will be held liable for these accounts.

11.9 **PLATINUM HEALTH MEDICAL SCHEME MAY RECORD CALLS**

Platinum Health Medical Scheme may record telephone conversations with you and your dependants. The recordings and all information we receive during the recordings, will be processed and kept as required by law.

Principal Member Signature:

Date: C C Y Y M M D D

DID YOU REMEMBER TO ATTACH THE FOLLOWING DOCUMENTATION REQUIRED WHEN REGISTERING DEPENDANTS?

1. SPOUSE – COPY OF SPOUSE'S IDENTITY DOCUMENT AND MARRIAGE CERTIFICATE
2. CHILDREN / STEPCHILD – CERTIFICATE OF BIRTH / IDENTITY DOCUMENT
3. CHILDREN 21 YEARS OR OLDER – PROOF OF STUDY AND PROOF OF DEPENDANT CHILD'S INCOME
4. ADOPTED CHILDREN – COURT ORDER, IDENTITY DOCUMENT, BIRTH CERTIFICATE
5. FIANCÉE / COMMON-LAW PARTNER / LIFE PARTNER – AFFIDAVIT, IDENTITY DOCUMENT
6. PARENTS (NO IN-LAWS) – AFFIDAVIT, PROOF OF INCOME, IDENTITY DOCUMENT

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